

REQUEST FOR MEDICARE PART D DRUG PLAN COMPARISON

By completing this form, the requester will receive by mail, fax, or email, a Part D general comparison listing the three lowest annual cost plans as published on www.medicare.gov. The State Health Insurance Assistance Program (SHIP) is a program of the State's Department of Insurance and will provide this information at no cost and does not endorse any of the plans. This form should be mailed to the Indiana Department of Insurance, State Health Insurance Assistance Program (SHIP) ATTN: DARLENE COLEMAN 714 W. 53rd St., Anderson, IN, 46013, or faxed to 765-608-2322. Please provide the following information:

Zip Code: _____

Do you get Extra Help Paying for Your Drug Cost? Not sure – see the bottom of the back page. Yes (Full ☐ Partial ☐ No ☐

Do you want your health and drug coverage together in one plan? Yes ☐ No ☐

Will you use lower cost generics? Yes ☐ No ☐

Can you afford to pay a deductible? Yes ☐ How much? _____ No ☐

Is there a limit on the monthly premium? Yes ☐ How much? _____ No ☐

This comparison should be returned to: Client _____ Counselor _____

Phone Number: _____

Name: _____

Address: _____

City, State, and Zip Code _____

PLEASE COMPLETE DRUG INFORMATION ON BACK OF THIS PAGE

OFFICE USE ONLY

Date Received: _____ Processed Date: _____ By: _____

Plan ID: _____ Password: _____

Date emailed: _____ Mailed: _____ Faxes: _____

Phone Contact: _____ Counseled Client: _____

Please list your drugs and dosages as they appear on your prescription bottle or package on the chart on back of this form. Make sure that you spell the name of the drug correctly. Do not include over-the-counter medications such as pain relievers and vitamins. **Which Pharmacy do you use?** _____

DRUG NAME – this must be spelled correctly	DOSAGE	QUANTITY PER DAY	REFILL FREQUENCY (1 or 3 months)

You may qualify for extra help paying for your Part D prescription costs if your resources are limited to \$13,070 for an individual or \$26,120 for a married couple living together. Your annual income must also be limited to \$16,755 for an individual or \$22,695 for a married couple living together. Even if your annual income is higher, you still may be able to get some help. For more information, contact your local Area Agency on Aging at 1-800-986-3505 or call SHIP at 1-800-452-4800,



LOCAL HELP FOR PEOPLE WITH MEDICARE